NC DIVISION MH/DD/SAS
MEDICAID SERVICES AUDIT ~ 2006/2007

PROVIDER NAME:			**AUDIT DATE:**	
PROVIDER #:			**NAME:**	
CONTROL #:			**SERVICE TYPE:**	
MEDICAID #:			**PROCEDURE CODE:**	
DOB/AGE:			**SERVICE DATE:**	
RECORD #:			**UNITS BILLED:**	
RATING CODES:	**O = Not Met/No** **1 = Met/Yes**	**6 – No service note** **7 = Provider name not available**	**8 = Repaid before audit list sent** **9 = NA**	**RATING**

SERVICE ORDER / SERVICE PLAN / SERVICE DOCUMENTATION:		
1. a. Was an authorization in place covering this date of service? **b. If "a" is NOT MET, was a request for authorization submitted prior to this date of service?** **c. If "b" is NOT MET, list dates: FROM_____ TO_____**	**a.** **b.**	
2. Is there a valid service order for the service billed? **a. If NOT MET, list dates: FROM_____ TO_____**		
3. Is the service plan current with the date of service? **a. If NOT MET, list dates: FROM_____ TO_____**		
4. Does the service plan identify the type of service billed? **a. If NOT MET, list dates: FROM _____ TO_____**		
5. Is the documentation signed by the person who delivered the service? ***[Service notes must have full signatures including credentials/position, by all providers, (no initials).]***		
6. Does the service note reflect purpose of contact, staff intervention, and assessment of progress toward goals?		
7. Does the service note relate to the individual's goals as listed in the service plan?		
8. Does the service documented indicate the specific requirements from the 3/27/06 Service Definitions Manual were met? ***(see specific requirements, Q8, Auditor's Instructions)***		
9. Are the service notes and service plan individualized per person?		
10. Do the units billed match the duration of service?		
11. Does the documentation reflect treatment for the duration of service?		
TRAINING/QUALIFICATIONS/SUPERVISION (List names of staff not in compliance)		
12. Is there documentation that the staff is qualified (demonstrates knowledge, skills and abilities per provider policy) for the service provided?		
13. a. Is an individualized supervision plan in place for paraprofessional and/or associate professional staff? **b. Is the plan implemented?** **c. If "b" is NOT MET, list dates: FROM:_____ TO:_____**	**a.** **b.**	
14. Did the provider agency require disclosure of any criminal conviction by the staff person(s) who provided this service?		
15. Did the provider agency complete a Health Care Personnel Registry check prior to this date of service?		

COMMENTS:

AUDITOR:	**LME:**